The Seven Deadly Sins of Mental Health Reform

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While continuing to be an enthusiastic supporter of efforts to improve our mental health services, I fear that mental health care reform has jumped the tracks and is careening wildly off course. Change, which should be based on evidence of improved effectiveness, is increasingly driven by fad and ideology. To illustrate these trends, I describe seven erroneous but influential principles that are currently shaping changes to our mental health system.

1 Inpatient versus community-based care.

The most egregious of the seven sins is the Orwellian-like proposition that all community-based psychiatric care is good and that all in-patient psychiatric care is bad! This fallacious and dangerous belief regretfully governs many approaches to mental health care reform. Consider the Ontario Ministry of Health statement that the reform’s primary goal is “maintaining people in the community and minimizing the need for hospitalization” (1). Surely, the primary objectives of all health care should be to reduce morbidity and mortality and to improve functioning and quality of life. Hospitalization, either increased or decreased, should not be viewed as a primary health care outcome. Clearly, if we wish to reduce hospitalization we can simply close hospitals. I am particularly concerned that clinical researchers are increasingly adopting level of hospital use as the primary outcome measure in psychiatric services research (2,3).

There are cogent arguments against the continuing use of the traditional asylum as a long-term residence for individuals with serious mental illness (4). However, it appears that some planners do not distinguish between acute-treatment beds and long-stay (residential) beds. A community-based mental health system must have enough treatment beds to assist acutely ill individuals. Care provided in the safe environment of a hospital is often the critical factor in resolving acute psychiatric disturbances (5). For many patients, the fabled “community” is a hostel room shared with a cocaine-abusing individual with paranoia—an environment that is hardly conducive to recovery.

In our haste to close psychiatric beds, we continue to ignore deinstitutionalization’s established effects: we know that when there are too few beds, many individuals with mental illness end up in prisons (6,7), or on the streets (8), or that the burden of their psychiatric care falls to the family (9,10). Even when these realities are grudgingly acknowledged, they are quickly dismissed with promises of diversion programs or more supportive housing. While these are good programs in and of themselves, their existence does not justify devaluing hospitalization to the option of last resort.

Reduced hospitalization is a logical objective only if you are a fiscal conservative, unconcerned with the well-being of those with mental illness. Fiscally conservative “spin-doctors” would have us believe that we can improve service while simultaneously saving money: real doctors know that the equation is very different!

The second sin is the mistaken belief that individuals with severe mental illness primarily need support, not treatment. Once again, an example from Ontario illustrates this. The Ontario Ministry of Health planning document *Putting People First* identified four central services: case management, 24-hour crisis intervention, housing and supports run by consumer survivors and families (11). Treatment, either pharmacotherapy or psychosocial, was seen as of secondary importance to a properly functioning mental health service. *Putting People First* is really about “putting support first.”

Research in the field of severe mental illness demonstrates the importance of improving reality testing and cognitive functioning before starting, or in tandem with rehabilitation efforts (12–14). Moreover, the available evidence indicates that treatment delays may result in a poor long-term prognosis (15–18). Yes, we need to attend to the social aspects of caring for people with mental illness but we should not neglect the essential work of assertively treating illness with the various effective tools at our disposal.

Serious mental illnesses are not discrete entities; rather they lie on a continuum with general emotional distress.

It has been argued that serious illnesses such as schizophrenia and bipolar disorder are extreme manifestations of ubiquitous forms of emotional distress and that their incidence can be reduced by aggressively treating less severe psychological disorders. Of course, there is not a scrap of evidence to support such a contention. Attempts to portray psychotic illnesses as existing on a continuum with less severe psychiatric disorders are just the latest ploy in a long-standing effort to divert funding from services that treat seriously ill individuals—who have difficulty lobbying for themselves—to less seriously ill individuals, who lobby effectively (19).

Part of this campaign to divert funding has been the effort to de-emphasize the medical nature of severe mental illness. In the face of incontrovertible evidence that schizophrenia and bipolar disorder are genetic illnesses (20,21) with a biological basis (22,23), the battle lines have been redrawn. The position of the traditional antimedical lobby can now be paraphrased thus: “these disorders may have a biological component, but what people who suffer from them need is a job and a friend, not treatment!” (See sin number two.)

Indeed, the latest iteration of the campaign to de-emphasize the medical nature of these diseases is the effort to abandon the term “patient” in favor of the business-orientated terms “consumer” and “client” or the politically fuelled juxtaposition “consumer-survivor.” Somewhat amazingly, in their haste to abandon the term “patient,” supporters of alternative terms neglected to do the obvious—to consider what the people who receive services would prefer to be called. A recent Canadian study reported that most people receiving services at several different types of hospital setting in Ontario preferred the term “patient” (24).

Mental health legislation designed for an institution-based system will work equally well when most psychiatric services are delivered in the community.

Deinstitutionalization has resulted in community-based management of individuals with progressively more severe conditions. Lack of insight is a common feature of psychotic disorders such as schizophrenia (25) and often leads to non-adherence to medication (26) and psychosocial treatment (27). This in turn can lead to a range of negative outcomes for those with mental illness and for society in general (28). Lack of insight and the risks associated with untreated psychotic illness make mandatory treatment necessary for a subgroup of patients. This need is not obviated when we attempt to treat these individuals in the community. Mandatory outpatient treatment can be administered in various ways. Two models adopted in Canada (British Columbia’s conditional leave and the community treatment orders used in Ontario and Saskatchewan) require that patients continue to meet civil commitment criteria (29). The effect is that these legal tools shift the locus of treatment from the hospital to the community, allowing treatment in the least restrictive location. Failure to adopt legislation compatible with treating seriously afflicted patients in the community will surely exact an ongoing toll of preventable suicides, homicides and death through neglect.

Paternalism versus libertarianism.

The fifth flawed philosophy of mental health care reform is the notion that perceived past abuses associated with an overly paternalistic system will be corrected by embracing an excessively libertarian approach. This, however, ignores the responsibility of professionals to people with serious mental illness. Surely, the old maxim “two wrongs don’t make a right” applies here. In the past, some patients were indeed treated poorly when hospitalized (30),
but lack of adequate funding for the large asylums was the major cause of their horrendous state. The remedy for past mistreatment is not to ban hospitalization or psychiatric treatment. Rather, it is first to provide adequate funding and then to ensure appropriate monitoring of in-patient care through such safeguards as advocacy and an effective appeal process.

6. “Consumers” should direct mental health services.

The sixth faulty tenet is that people who refer to themselves as “consumer-survivors” should have the final say in all philosophical and practical issues pertaining to the delivery of mental health services. The suggested rationale for this approach is that the consumer-survivors who have serious mental illness have the necessary knowledge and expertise to make these decisions and are the only unbiased stakeholders.

I fear that this may be the most controversial issue addressed in this article. However, we cannot continue to ignore the problems inherent in accepting the above proposal. Only a few self-proclaimed consumer-survivors who are active in planning, advocacy or self-help programs have severe and persistent mental illness such as schizophrenia. The paradox is evident: very severe mental disorders like process schizophrenia are associated with chronic symptoms such as impaired reality testing, cognitive impairment, reduced motivation and deterioration of interpersonal skills. Most people with these characteristics are unable to participate effectively in planning or administering services. It is more likely that individuals who are active in planning and administration will have had a single episode of illness or perhaps a recurrent pattern of illness with full recovery between episodes. The issues for these individuals are not the same as for those who suffer from severe and persistent mental illness. The voice of various consumer groups should be heard (even those strident anti-psychiatry voices), but the limitations of their constituency must be acknowledged.

So who should represent the needs of individuals with severe and persistent mental illness? I believe that the families of these individuals should take the lead role. This has happened in similar circumstances (for example, with the relatives of individuals with developmental delay or Alzheimer’s disease). While it has been suggested that clinicians should be excluded from mental health care planning to avoid any possible conflict of interest, the results of this policy in the area of general medical care have been disastrous (31). Abandoning all professional expertise distances decision making from front-line clinical work; clinicians must insist on taking an active role in health care planning. We must also acknowledge, however, that the exclusively medical administration of mental health services in the past did not provide optimum services to patients. Including diverse voices can only help the system.

7. Responsibility and funding.

The final sin of mental health care reform is the mistaken belief that it is not necessary to link funding for mental health services to responsibility for providing treatment and care for specific groups of patients. History shows that wherever possible society will ignore the needs of those with serious mental illness. Thus, the Community Mental Health Centers developed in the United States in the 1960s to provide treatment to patients discharged from state hospitals did just about everything but treat patients with serious mental illness (32). In Canada, the current funding shift from institutional to community mental health programs runs a similar risk of diverting funds. Traditionally, psychiatric hospitals have served a catchment area. These hospitals are often the port of last call for individuals with serious illness; they have assumed the responsibility of providing treatment and overall care for those patients who could not be treated elsewhere. In developing a new system, governments must ensure that funded agencies serve their intended target population, using interventions with proven efficacy.

While this essay may appear to be an indictment of mental health care reform, I hope that it will generate constructive discussion. Indeed, it is illogical to be for or against mental health care reform. Rather, the nature of any proposed reform and the evidence demonstrating its effectiveness should determine our support. Let us try to move forward on the basis of what is best for our patients and not on fiscal priorities, political expediency or untested ideologies.

References

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